Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

CERTIFICATION OF POSTGRADUATE TRAINING FOR USMLE EXAMINATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, you will be ineligible to sit for the exam

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For Section II, send this form to be completed by the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

SECTION I - APPLICATION INFORMATION

First Name	Middle Name	Last Name
Social Security Number		Date of Birth
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.

Name

TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital

Street Address of Hospital

City, State and ZIP Code

I certify that _____, **a graduate of the**
(Applicant's Name)

_____ **medical school, has successfully completed postgraduate**

clinical training offered by the hospital named above from _____, **to** _____,
Month/Day/Year Month/Day/Year

in the clinical area of _____.

Is this training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training programs of the Canadian Medical Association?

☐ **Yes** ☐ **No**

_____ _____
Signature of Director of Medical Education Date of Signature

_____
Print or Type Name of Director of Medical Education

(S E A L)

If hospital has no seal, please indicate

NOTE: **This form may not be completed and submitted to the Board office prior to the completion of the required 6 months of post graduate training.**

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DCH/LMD-050 (03/04)

Board Use Only

APPLICATION FOR USMLE STEP 3 EXAMINATION

Authority: Public Act 368 of 1978, as amended

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

☐ **USMLE Step 3 Examination Fee: $50.00 71-4301-25**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan Permanent I. D. Number and Expiration Date
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you previously taken USMLE Step 3 in Michigan?	☐ **Yes**	☐ **No**
2. Have you previously taken USMLE Step 3 in another State? If yes, Please list state(s) and date of exam.	☐ **Yes**	☐ **No**
3. Do you now or have you ever held an educational limited license in the State of Michigan? If yes, please give license number below.	☐ **Yes**	☐ **No**

ELIGIBILITY

To be eligible to take USMLE step 3, you must establish BOTH of the following:

a) **That you have passed USMLE Step 1 and USMLE Step 2 and**

b) **That you have completed not less than six months of postgraduate clinical training in a program approved by board.**

INSTRUCTIONS TO APPLICANT

It is your responsibility to assure that the following two documents are provided to this office directly from their sources:

1) **USMLE Step 1 and USMLE Step 2 examination scores from the Federation of State Medical Boards and**

2) **Certification of completion of at least six months postgraduate clinical training on the enclosed form from your Program Director**

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.